Emergency Support Function #8
Health and Medical Services Annex

Primary Agency:	Department of Health and Human Services
Support Agencies:	Department of Agriculture Department of Defense Department of Energy Department of Justice Department of Transportation Department of Veterans Affairs Agency for International Development American Red Cross Environmental Protection Agency Federal Emergency Management Agency General Services Administration National Communications System U.S. Postal Service

I. Introduction

A. Purpose

Emergency Support Function (ESF) #8 — Health and Medical Services provides coordinated Federal assistance to supplement State and local resources in response to public health and medical care needs following a major disaster or emergency, or during a developing potential medical situation. Assistance provided under ESF #8 is directed by the Department of Health and Human Services (HHS) through its executive agent, the Assistant Secretary for Health (ASH). Resources will be furnished when State and local resources are overwhelmed and public health and/or medical assistance is requested from the Federal Government.

B. Scope

1. ESF #8 involves supplemental assistance to State and local governments in identifying and meeting the health and medical needs of victims of a major disaster, emergency, or terrorist attack. This support is categorized in the following functional areas:

   a. Assessment of health/medical needs;

   b. Health surveillance;

   c. Medical care personnel;

   d. Health/medical equipment and supplies;

e. Patient evacuation;

f. In-hospital care;

g. Food/drug/medical device safety;

h. Worker health/safety;

i. Radiological/chemical/biological hazards consultation;

j. Mental health care;

k. Public health information;

l. Vector control;

m. Potable water/wastewater and solid waste disposal;

n. Victim identification/mortuary services; and

o. Veterinary services.

2. HHS, in its primary agency role for ESF #8, coordinates the provision of Federal health and medical assistance to fulfill the requirements identified by the affected State and local authorities having jurisdiction. Included in ESF #8 are overall public health response; triage, treatment, and transportation of victims of the disaster; and evacuation of patients out of the disaster area, as needed, into a network of Military Services, Veterans Affairs, and pre-enrolled non-Federal hospitals located in the major metropolitan areas of the United States. ESF #8 will utilize resources primarily available from:

   a. Within HHS;

   b. ESF #8 support agencies;

   c. The National Disaster Medical System (NDMS), a nationwide medical mutual aid network between the Federal and non-Federal sectors that includes medical response, patient evacuation, and definitive medical care. At the Federal level, it is a partnership between HHS, the Department of Defense (DOD), the Department of Veterans Affairs (VA), and the Federal Emergency Management Agency (FEMA); and

   d. Specific non-Federal sources such as major pharmaceutical suppliers, hospital supply vendors, the National Foundation for Mortuary Care, certain international disaster response organizations and international health organizations.

II. Policies

A. ESF #8 will be implemented upon the appropriate State-level request for assistance following the occurrence of a major disaster or emergency and after determination has been made by FEMA that a Federal response is warranted.

B. The ASH is responsible for activating and coordinating the activities of ESF #8. The lead policy official for ESF #8 supporting the ASH is the Principal Deputy Assistant Secretary for Health (PDASH). The HHS Office of Emergency Preparedness (HHS/OEP) is the action agent and is responsible for coordinating the implementation of ESF #8 and providing staff support to the HHS policy officials. The HHS Regional Health Administrators (RHAs) are the operating agents and are responsible for directing regional ESF #8 activities.

C. The national HHS Emergency Operations Center (EOC)/NDMS Operations Support Center (OSC) (HHS EOC/NDMSOSC) will provide liaison between the Federal Government headquarters and appropriate regional officials in the response structure at the disaster scene for the coordination of Federal health and medical assistance to meet the requirements of the situation. The HHS EOC will coordinate and facilitate the overall ESF #8 response.

D. In accordance with assignment of responsibilities in ESF #8, and further tasking by the primary agency, each support agency will contribute to the overall response but will retain full control over its own resources and personnel.

E. ESF #8 is the primary source of public health and medical response/information for all Federal officials involved in response operations.

F. All national and regional organizations (including other ESFs) participating in response operations will report public health and medical requirements to their counterpart level (national or regional) of ESF #8.

G. To ensure patient confidentiality protection, ESF #8 will not release medical information on individual patients to the general public.

H. Appropriate information on casualties/patients will be provided to the American Red Cross (ARC) for inclusion in the Disaster Welfare Information (DWI) system for access by the public.

I. Requests for recurring reports of specific types of public health and medical information will be submitted to ESF #8. ESF #8 will develop and implement procedures for providing these recurring Situation Reports (SITREPs).

J. The primary Joint Information Center (JIC), established in support of the Federal Response Plan (FRP), will be authorized to release general medical and public health response information to the public. Other JICs may also release general medical and public health response information at the discretion of the lead Public Affairs Officer.

III. Situation

A. Disaster Condition

1. A significant natural disaster or man-made event that overwhelms the affected State would necessitate both Federal public health and medical care assistance. Hospitals, nursing homes, ambulatory care centers, pharmacies, and other facilities for medical/health care and special needs populations may be severely structurally damaged or

destroyed. Facilities that survive with little or no structural damage may be rendered unusable or only partially usable because of a lack of utilities (power, water, sewer) or because staff are unable to report for duty as a result of personal injuries and/or damage/disruption of communications and transportation systems. Medical and health care facilities that remain in operation and have the necessary utilities and staff will probably be overwhelmed by the "walking wounded" and seriously injured victims who are transported there in the immediate aftermath of the occurrence. In the face of massive increases in demand and the damage sustained, medical supplies (including pharmaceuticals) and equipment will probably be in short supply. (Most health care facilities usually maintain only a small inventory stock to meet their short-term, normal patient load needs.) Disruptions in local communications and transportation systems could also prevent timely resupply.

2. Uninjured persons who require daily or frequent medications such as insulin, antihypertensive drugs, digitalis, and dialysis may have difficulty in obtaining these medications and treatments because of damage/destruction of normal supply locations and general shortages within the disaster area.

3. In certain other disasters, there could be a noticeable emphasis on relocation, shelters, vector control, and returning water, wastewater, and solid waste facilities to operation.

4. A major medical and environmental emergency resulting from chemical, biological, or nuclear weapons of mass destruction could produce a large concentration of specialized injuries and problems that could overwhelm the State and local public health and medical care system.

B. Planning Assumptions

1. Resources within the affected disaster area will be inadequate to clear casualties from the scene or treat them in local hospitals. Additional mobilized Federal capabilities will be urgently needed to assist State and local governments to triage and treat casualties in the disaster area and then transport them to the closest appropriate hospital or other health care facility. Additionally, medical resupply will be needed throughout the disaster area. In a major disaster, operational necessity may require the further transportation by air of patients to the nearest metropolitan areas with sufficient concentrations of available hospital beds, where patient needs can be matched with the necessary definitive medical care.

2. A terrorist release of weapons of mass destruction; damage to chemical and industrial plants, sewer lines, and water distribution systems; and secondary hazards such as fires will result in toxic environmental and public health hazards to the surviving population and response personnel, including exposure to hazardous chemicals, biologicals, radiological substances, and contaminated water supplies, crops, livestock, and food products.

3. The damage and destruction of a major disaster, which may result in multiple deaths and injuries, will overwhelm the State and local mental health system, producing an urgent need for mental health crisis counseling for disaster victims and response personnel.
4. Assistance in maintaining the continuity of health and medical services will be required.
5. Disruption of sanitation services and facilities, loss of power, and massing of people in shelters may increase the potential for disease and injury.
6. Primary medical treatment facilities may be damaged or inoperable; thus, assessment and emergency restoration to necessary operational levels is a basic requirement to stabilize the medical support system.

IV. Concept of Operations

A. General

1. Upon notification of a major disaster or emergency, HHS (as primary agency) will alert the HHS EOC staff to assemble in the HHS EOC. The ASH, PDASH, HHS Agency Emergency Coordinators (AECs), and appropriate HHS RHAs, Regional Emergency Coordinators, and Regional Directors (RDs) will be notified.
2. The ASH will direct the activities of ESF #8 and will activate the NDMS as needed.
3. Pre-identified personnel will be alerted to meet requirements for representing ESF #8 on the:
   a. Catastrophic Disaster Response Group (CDRG);
   b. Emergency Support Team (EST);
   c. National ESF #8 EOC;
   d. Regional ESF #8 Coordination Center;
   e. Regional Operations Center (ROC); and
   f. Emergency Response Team — Advance Element (ERT-A).
4. All support agencies will be notified and tasked to provide 24-hour representation as necessary. Each support agency is responsible for ensuring that sufficient program staff is available to support the HHS EOC and to carry out the activities tasked to its agency on a continuous basis. Individuals representing agencies who are staffing the HHS EOC will have extensive knowledge of the resources and capabilities of their respective agencies and have access to the appropriate authority for committing such resources during the activation.
5. National ESF #8 will provide liaison and communications support to regional ESF #8 to facilitate direct communications between them. The national ESF #8 personnel will be deployed as necessary to assist regional ESF #8 in establishing and maintaining effective coordination within the disaster area.

6. Regional ESF #8 will coordinate with the appropriate State medical and public health officials and organizations to determine current medical and public health assistance requirements.

7. Regional ESF #8 will be supported by the Joint Regional Medical Planning Office (JRMPO) or other entity designated by the DOD Defense Coordinating Officer (DCO) to coordinate civil authority requests for military resource support within the disaster area. Regional ESF #8 also will be assisted by those other support agencies as contained in the regional ESF #8 appendices.

8. Regional ESF #8 will utilize locally available health and medical resources to the extent possible to meet the needs identified by State and local authorities. National ESF #8 will meet the additional requirements primarily from pre-arranged sources throughout the United States and Canada.

9. During the response period, ESF #8 will evaluate and analyze medical and public health assistance requests and responses, and develop and update assessments of medical and public health status. ESF #8 will maintain accurate and extensive logs to support after-action reports and other documentation of the disaster conditions.

10. In the early stages of a disaster response, it may not be possible to fully assess the situation and verify the level of assistance required. In such circumstances, national ESF #8, in consultation with regional ESF #8, reserves the right to decide whether to authorize assistance. In these cases, every attempt will be made to verify the need before providing assistance.

11. ESF #8 will develop and provide medical and public health situation reports to the CDRG, EST, ERT, primary JIC, and organizations with a need for recurring reports of specific types of information including other ESFs, Federal agencies, and the State upon request. Information will be disseminated by all available means including fax, telephone, radio, memoranda, display charts and maps, and verbal reports at meetings and briefings.

B. Organization

1. National-Level Response Structure

a. ESF #8 response will be activated and directed by the ASH. The HHS EOC will become operational. The HHS EOC will consist of a core of Federal agencies that will be supplemented by other national-level organizations, governmental and private, as the situation dictates. During the initial activation, the principal core staff will consist of a pre-designated HHS EOC staff and representatives from the Assistant Secretary of Defense (Health Affairs), DOD; Under Secretary for Health, VA; and Director, FEMA.

b. Additional supporting agencies and organizations will be alerted and will be tasked either to provide a representative to the HHS EOC or to provide a representative who will be immediately available via telecommunications (telephone, fax, conference calls, etc.) to provide support.

c. HHS will identify and provide personnel to represent HHS and national ESF #8 both on the CDRG and the EST. HHS also will dispatch, as needed, emergency response coordinators and the national ESF #8 ERT to the disaster area to support the lead RHA with responsibility for the regional ESF #8.

d. Coordination of ESF #8 will be centralized at the HHS EOC.

e. Special advisory groups of health/medical subject matter experts will be assembled and consulted by national ESF #8 as needed.

2. Regional-Level Response Structure

a. The RHA, the lead for the regional ESF #8 health and medical response, will establish a regional ESF #8 Coordination Center (CC) and provide administrative support to the regional response activities. The HHS RD will assist the RHA by coordinating human services support required from the other HHS operating divisions located within the region.

b. The lead for regional ESF #8 will represent ESF #8 in its dealings with the Federal Coordinating Officer (FCO) and will maintain liaison with the FCO, the appropriate State and local health and medical officials, national ESF #8, and the HHS RD.

c. Regional ESF #8 will have appropriate representatives available to rapidly deploy, with the ERT-A, to the affected State's EOC or other designated location.

d. Regional ESF #8 will have appropriate representative(s) present or available by telephone or radio at the regional ESF #8 CC, and additionally at the ROC and/or Disaster Field Office (DFO), as required by the FCO, on a 24-hour basis for the duration of the emergency response period. Other representatives of the lead/support agencies will be available to staff the ROC and/or the DFO upon request of the lead of regional ESF #8.

C. Notification

1. Upon the occurrence of a potential major disaster or emergency, the FEMA National Emergency Coordination Center will notify the ESF #8 action agent (HHS/OEP). The affected FEMA region will notify the HHS RHA. Notification can be made via telephone, fax, or digital pagers. Such notification could be to advise of the potential disaster, convene the CDRG, request an ESF #8 representative to deploy as a regional ERT member, establish the EST at FEMA Headquarters, or pass a request from regional or State officials seeking activation of NDMS.

2. HHS/OEP will notify the ASH and request activation of ESF #8. HHS/OEP will alert its EOC staff, which in turn will notify the lead regional ESF #8 by telephone or radio, if possible. If the RHA or the appropriate representative cannot be contacted, the HHS RD will be notified and requested to advise the regional ESF #8 lead. If the HHS RD cannot be contacted, the ESF #8 lead of an adjacent region will be contacted and requested to assist in notifying and establishing the regional ESF #8 in the disaster area.

3. The HHS/OEP EOC staff also will notify all other national ESF #8 members by the most expeditious communications method.

4. Upon notification, ESF #8 members will notify their parent agencies. ESF #8 members will report to the appropriate location(s) as directed (such as HHS EOC, FEMA Headquarters, etc.) and regional ESF #8 members will report to the appropriate location(s) as directed (such as the ROC or DFO).

D. Response Actions

1. Initial Actions Following a Potential Major Disaster or Emergency

The HHS EOC will become operational within 2 hours of notification. Until the regional ESF #8 becomes operational, the collection, analysis, and dissemination of requests for medical and public health assistance will be the responsibility of national ESF #8, with the assistance of the HHS region. Upon declaration by the RHA that the regional ESF #8 CC is operational, the major responsibilities for requests for medical and public health assistance will be transferred to regional ESF #8. National ESF #8 will conduct the following actions while bringing ESF #8 to a fully operational status:

a. Federal health and medical assistance is generally categorized into the major functions of prevention, medical services, mental health services, and environmental health. Each of the 15 specific functional areas is contained in one of these categories. Upon notification of the occurrence of a potential major disaster or emergency, the lead of the national ESF #8 (the ASH) will request HHS and support agencies to initiate action immediately to identify and report the potential need for Federal health and medical support to the affected disaster area in the following functional areas:

(1) Assessment of Health/Medical Needs

Lead HHS Agency: Office of Public Health and Science/Office of Emergency Preparedness/National Disaster Medical System (OPHS/OEP/NDMS): Mobilize and deploy an assessment team to the disaster area to assist in determining specific health/medical needs and priorities. The composition of the assessment team will be jointly determined by the action agent and the operating agent based on the type and location of the emergency. This function includes the assessment of the health system/facility infrastructure.

(2) Health Surveillance

Lead HHS Agency: Centers for Disease Control and Prevention: Assist in establishing surveillance systems to monitor the general population and special high-risk population segments; carry out field studies and investigations; monitor injury and disease patterns and potential disease outbreaks; and provide technical assistance and consultations on disease and injury prevention and precautions.

(3) Medical Care Personnel

Lead HHS Agency: OPHS/OEP/NDMS: Provide Disaster Medical Assistance Teams (DMATs) and individual public health and medical personnel to assist in providing care for ill or injured victims at the location of a disaster or emergency. DMATs can provide triage, medical or surgical stabilization, and continued monitoring and care of patients until they can be evacuated to locations where they will receive definitive medical care. Specialty DMATs can also be deployed to address mass burn injuries, pediatric care requirements, chemical injury or contamination, etc. In addition to DMATs, Active Duty, Reserve, and National Guard units for casualty clearing/staging and other missions will be deployed as needed. Individual clinical health and medical care specialists may be provided to assist State and local personnel. The VA is one of the primary sources of these specialists.

(4) Health/Medical Equipment and Supplies

Lead HHS Agency: OPHS/OEP/NDMS: Provide health and medical equipment and supplies, including pharmaceuticals, biologic products, and blood and blood products, in support of DMAT operations and for restocking health and medical care facilities in an area affected by a major disaster or emergency.

(5) Patient Evacuation

Lead HHS Agency: OPHS/OEP/NDMS: Provide for movement of seriously ill or injured patients from the area affected by a major disaster or emergency to locations where definitive medical care is available. NDMS patient movement will primarily be accomplished utilizing fixed-wing aeromedical evacuation resources of DOD; however, other transportation modes may be used as circumstances warrant.

(6) In-Hospital Care

Lead HHS Agency: OPHS/OEP/NDMS: Provide definitive medical care to victims who become seriously ill or injured as a result of a major disaster or emergency. For this purpose, NDMS has established and maintains a nationwide network of voluntarily pre-committed, non-Federal, acute care hospital beds in the largest U.S. metropolitan areas.

(7) Food/Drug/Medical Device Safety

Lead HHS Agency: Food and Drug Administration: Ensure the safety and efficacy of regulated foods, drugs, biologic products, and medical devices following a major disaster or emergency. Arrange for seizure, removal, and/or destruction of contaminated or unsafe products.

(8) Worker Health/Safety

Lead HHS Agency: Centers for Disease Control and Prevention: Assist in monitoring health and well-being of emergency workers; perform field investigations and studies addressing worker health and safety issues; and provide technical assistance and consultation on worker health and safety measures and precautions.

(9) Radiological/Chemical/Biological Hazards Consultation

Lead HHS Agency: Centers for Disease Control and Prevention: Assist in assessing health and medical effects of radiological, chemical, and biological exposures on the general population and on high-risk population groups; conduct field investigations, including collection and analysis of relevant samples; advise on protective actions related to direct human and animal exposure, and on indirect exposure through radiologically, chemically, or biologically contaminated food, drugs, water supply, and other media; and provide technical assistance and consultation on medical treatment and decontamination of radiologically, chemically, or biologically injured/contaminated victims.

(10) Mental Health Care

Lead HHS Agency: Substance Abuse and Mental Health Services Administration: Assist in assessing mental health needs; provide disaster mental health training materials for disaster workers; and provide liaison with assessment, training, and program development activities undertaken by Federal, State, and local mental health officials.

(11) Public Health Information

Lead HHS Agency: Centers for Disease Control and Prevention: Assist by providing public health and disease and injury prevention information that can be transmitted to members of the general public who are located in or near areas affected by a major disaster or emergency.

(12) Vector Control

Lead HHS Agency: Centers for Disease Control and Prevention: Assist in assessing the threat of vector-borne diseases following a major disaster or emergency; conduct field investigations, including the collection and laboratory analysis of relevant samples; provide vector control equipment and supplies; provide technical assistance and consultation on protective actions regarding vector-borne diseases; and provide technical assistance and consultation on medical treatment of victims of vector-borne diseases.

(13) Potable Water/Wastewater and Solid Waste Disposal

Lead HHS Agency: Indian Health Service: Assist in assessing potable water and wastewater/solid waste disposal issues; conduct field investigations, including collection and laboratory analysis of relevant samples; provide water purification

and wastewater/solid waste disposal equipment and supplies; and provide technical assistance and consultation on potable water and wastewater/solid waste disposal issues.

(14) Victim Identification/Mortuary Services

Lead HHS Agency: OPHS/OEP/NDMS: Assist in providing victim identification and mortuary services, including NDMS Disaster Mortuary Teams (DMORTs); temporary morgue facilities; victim identification by fingerprint, forensic dental, and/or forensic pathology/anthropology methods; and processing, preparation, and disposition of remains.

(15) Veterinary Services

Lead HHS Agency: OPHS/OEP/NDMS: Assist in delivering health care to injured or abandoned animals and performing veterinary preventive medicine activities following a major disaster or emergency, including conducting field investigations and providing technical assistance and consultation as required.

b. National ESF #8 also will initiate the following alerting actions:

(1) Alert and deploy national ESF #8 representative(s) to the EST;

(2) Alert national ESF #8 representative(s) to be on standby to deploy to the disaster area as a member of the national ESF #8 ERT;

(3) Alert and deploy national ESF #8 Management Support Unit (MSU) to the disaster area to provide liaison and support to regional ESF #8. The MSU will be self-contained as much as possible (tents, sleeping bags, food, etc.) and will provide some long-distance communications support for direct connectivity between the regional and national ESF #8;

(4) Request HHS EOC to alert NDMS Response Resources to be on a standby basis;

(5) Through its DOD representative, alert the Global Patient Movement Requirements Center (GPMRC) to prepare to receive hospital bed availability reports. GPMRC will establish an appropriate reporting window;

(6) Through VA, DOD representatives, and appropriate VA and Military Services command and control systems, alert local NDMS Federal Coordinating Centers (FCCs) to obtain bed availability reports from the participating non-Federal hospitals and report bed status to GPMRC;

(7) Alert HHS Supply Service Center, Defense Logistics Agency, and other pre-identified sources of medical supplies to be on a standby basis;

(8) Alert national-level communications and transportation support agencies to be on a standby basis; and

(9) Determine from ESF #5 — Information and Planning the geographic area affected by the disaster and obtain weather information for the disaster area, including present conditions, the 24-hour forecast, and the long-range forecast.

c. National ESF #8 primary and support agency members will report to the HHS EOC and convene within 2 hours following notification. Alternatively, ESF #8 members may be directed to report to their usual offices within 2 hours and thereafter maintain continuous telephone communication with national ESF #8.

d. The HHS EOC DOD representative will activate the national-level DOD support network as required. This alerting may include, but not be limited to, the Director of Military Support (DOMS); Surgeons General of the Army, Navy, and Air Force; U.S. Transportation Command (USTRANSCOM); Air Mobility Command (AMC); National Guard Bureau (NGB); GPMRC; Forces Command (FORSCOM); U.S. Atlantic Command (USACOM); U.S. Pacific Command (USPACOM); U.S. Southern Command (USSOUTHCOM); Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS); Medical Readiness Division, Office of the Joint Chiefs of Staff (J-4/JCS); and other appropriate DOD components. DOMS, in coordination with the Services and JCS executive agents (i.e., Headquarters U.S. Air Force (HQUSAF) Surgeon General for GPMRC) will, in turn, notify Service FCCs and other Service components as appropriate.

2. Continuing Actions

a. Situation Assessment

(1) The national ESF #8 staff will continuously acquire and assess information about the disaster situation. The staff will continue to attempt to identify the nature and extent of health and medical problems, and establish appropriate monitoring and surveillance of the situation to obtain valid ongoing information. National ESF #8 will primarily rely on information from the disaster area that is furnished by regional ESF #8. Other sources of information may include national ESF #8 support agencies, various Federal officials in the disaster area, State health officials, State emergency medical services (EMS) authorities, State disaster authorities, or the responsible jurisdiction in charge of the disaster scene. Information also may be acquired from Federal officials outside the disaster area, such as local NDMS FCCs, FEMA Regional Offices, and HHS Regional Offices.

(2) Because of the potential complexity of the health and medical response issues/situations, conditions may require special advisory groups of subject matter experts to be assembled by national ESF #8 to review health/medical intelligence information and advise on specific strategies to most appropriately manage and respond to a specific situation.

b. Activation of Health/Medical Response Teams

(1) By direction of the ASH, health personnel/teams from HHS will be deployed as needed, and appropriate medical and public health (including environmental health) assistance will be provided. NDMS DMATs will be activated and deployed as needed. The HHS EOC will respond to the direction by arranging for alerting, activation, appointment to Federal status (where appropriate), and deployment of NDMS DMATs. The HHS EOC, in cooperation with the MSU (when established), will coordinate and arrange for the necessary transportation and logistic support for the DMATs. DMATs may be activated for provision of patient reception, patient staging, casualty clearing, or other medical care activities in meeting the needs of the situation.

(2) Certain military medical units, including Active Duty, Reserve, and National Guard, may be tasked to deploy to support ESF #8 requirements. These requirements will be coordinated with the NDMSOSC DOD representative, who will coordinate with DOMS to activate and deploy the necessary military units. VA assets that are available for response activities include the Medical Emergency Radiological Response Teams (MERRTs) and the Emergency Medical Response Teams (EMRTs). The VA is also able to mobilize health professionals who are not necessarily part of a formal "team," depending on ESF #8 requirements.

c. Coordination of Requests for Medical Transportation

Arrangements for medical transportation should be made at the lowest levels possible. Normally, local transportation requirements are to be handled by local authorities. If it is determined by regional ESF #8 that local or regional resources are inadequate to meet the requirements, a request for Federal medical transportation assistance will be worked at the national ESF #8 level by use of the patient evacuation component of NDMS. Patient regulation will be the responsibility of GPMRC.

d. Coordination of Requests for Medical Facilities

Arrangements for medical facilities are primarily a local function. Requests for additional assistance should first be referred to State authorities. Requests by State officials for Federal aid for NDMS hospital support should be routed through regional ESF #8 to the NDMSOSC. The NDMSOSC will verify the request and refer it to the DOD and VA representatives. The VA and DOMS, through their Service representatives, will notify NDMS FCCs to activate area operations/patient reception plans. HQUSAF will alert GPMRC regarding NDMS activation. GPMRC will establish and disseminate appropriate bed reporting instructions to the FCCs. Further, the 375th Aeromedical Evacuation Squadron/Aeromedical Evacuation Control Center (AECC), Scott Air Force Base, IL (formerly the Patient Airlift Center), will provide appropriate patient reception/patient arrival information to GPMRC and local FCCs. Local FCCs, through their patient reception teams, will distribute arriving patients to specific NDMS-participating hospitals based on the patients' needs and facility capability.

e. Coordination of Requests for Aeromedical Evacuation of Patients from the Disaster Area

(1) State and local health/medical authorities identify the need for patient evacuation support from the disaster area. The requirement for aeromedical evacuation (AE) is communicated through regional ESF #8 to the NDMSOSC. The DOD representative in the NDMSOSC, in turn, will coordinate with the appropriate commands, such as FORSCOM, USTRANSCOM, USACOM, USPACOM, USSOUTHCOM, and/or HQAMC Command Centers. The agency contacted will then coordinate with the appropriate supporting command to obtain the needed support.

(2) The concept of operation is for local authorities to operate Casualty Collection Points (CCPs) that will feed into State-operated Regional Evacuation Points (REPs). ESF #8 will coordinate the hand-off of patients from the REPs into the NDMS patient evacuation system.

(3) Patient regulating is the responsibility of GPMRC. Because the movement of patients is based upon the availability of hospital beds, GPMRC will receive patient requirements from the disaster area and regulate patients to destination reception areas that report available beds. Regional ESF #8 will establish a Patient Reporting Activity (PRA) to report the number of patients requiring movement out of the area to GPMRC. Patients will be reported in the specified contingency categories. FCCs will likewise report available beds in the same contingency categories. Once the regulating decision is made, GPMRC will pass it to the PRA and the receiving FCCs. After receipt by the PRA, regional ESF #8 will coordinate with the State to have the patients moved. GPMRC can provide Joint Patient Movement Team(s) (JPMTs) that can manage patient regulating activities from the disaster site.

(4) AE resources will be deployed based on the nature of the disaster or emergency and estimated length of support requirement. In a limited operation, support may be restricted to providing Aeromedical Evacuation Crew Members (AECMs), airlift, and/or liaison personnel, with centralized management remaining with the AECC, Scott Air Force Base. In a larger or more prolonged event that may require sustained support, elements of the Tactical Aeromedical Evacuation System (TAES), to include an Aeromedical Evacuation Control Element (AECE), Mobile Aeromedical Staging Facility (MASF), Aeromedical Evacuation Liaison Team (AELT), and AECMs, may be deployed to the region. When deployed, the AECE will provide regional control for the AE elements, with overall responsibility for continental United States (CONUS) AE operations remaining with the AECC, Scott Air Force Base. Outside the continental United States (OCONUS), overall responsibility will rest with the appropriate military command — Commander-in-Chief Atlantic (CINCLANT), Commander-in-Chief Pacific (CINCPAC), or USSOUTHCOM — having military support responsibility for the geographic area of the disaster/emergency.

(a) An AELT could deploy to the REPs to provide a direct high frequency radio communications link and immediate coordination between the REP originating the requirements for aeromedical evacuation and the AECC. The primary mission of the AELT is to coordinate patient movement requests and the movement schedule between the AECC and the REP.

(b) The AECC is the operations center responsible for mission planning, coordinating, and management of the disaster area AE operations. The AECC establishes and is the focal point for communications and provides the source of direction and control for disaster area AE forces.

(c) The MASF is a mobile, tented, temporary staging facility deployed to provide supportive care and administration. It does not have beds or cots. Since it has no organic patient-carrying vehicles, it is normally located near runways, taxiways, or airfields.

(d) The AECMs provide in-flight supportive medical care aboard AE mission-directed aircraft.

(e) Control teams will be deployed to identify the closest appropriate hub site to the REP that can handle the AE aircraft, which is normally a C-9 or C-130. Aeromedical staging capability (utilizing a joint operation between military MASFs and NDMS DMATS) will be established near the runways or taxiways of the designated airfield or forward operating base. The regulated patients are then moved from the REP to the aeromedical staging location for entrance into the AE system and movement to the regulated destination.

(f) The AELT, AECC, and MASF have equipment and personnel to establish a communications network in support of the system. The AECC functions as the net control for the various elements.

(g) If AE elements are not deployed to the disaster area, personnel/ medical facilities reporting patient movement requirements should be prepared to provide as much medical information on patients as is known, e.g., current condition, diagnosis, vital signs, any special equipment requirements. A point of contact should be provided so the AECC can obtain any additional information needed to prepare for the mission.

(h) If State or local authorities request patient evacuation but are unable to establish REPs and/or CCPs, ESF #8 will deploy the necessary additional medical force structure to facilitate the lowest echelon level of care required to accomplish the mission successfully.

f. Coordination for Obtaining, Assembling, and Delivering Medical Equipment and Supplies to the Disaster Area

Representatives of HHS, VA, DOD, Department of Transportation (DOT), and General Services Administration will coordinate arrangements for the procurement and transportation of medical equipment and supplies to the disaster area. A "push" concept will be employed when feasible to expedite medical resupply to the disaster area from pre-identified medical supply caches. Included in this response will be the HHS-requested support, as needed, of certain medical supplies.

g. Communications

National ESF #8 will establish communications necessary to effectively coordinate assistance.

h. Information Requests

Requests for information may be received at ESF #8 from various sources, such as the media and the general public, and they will be referred to the appropriate agency or JIC for response.

i. After-Action Reports

The HHS/OEP will, upon completion of the emergency, prepare a summary after-action report. The after-action report, which summarizes the major activities of ESF #8, will identify key problems, indicate how they were solved, and make recommendations for improving response operations in subsequent activations. Support agencies will assist in the preparation of the after-action report and endorse the final report.

V. Responsibilities

A. Primary Agency: Department of Health and Human Services

1. Provide leadership in directing, coordinating, and integrating overall Federal efforts to provide medical and public health assistance to the affected area;
2. Direct the activation of NDMS and the staffing of the HHS EOC as necessary to support the emergency response operations;
3. Direct the activation and deployment of health/medical personnel, equipment, and supplies in response to requests for Federal health/medical assistance;
4. Coordinate the evacuation of patients from the disaster area when evacuation is deemed appropriate by State authorities;
5. Coordinate the provision of definitive health care through NDMS; and
6. Provide human services assistance under the direction of the HHS RD.

B. Support Agencies

1. Department of Agriculture, Forest Service

Provide appropriate personnel, equipment, food, and supplies, coordinated through the National Fire Suppression Liaison Officer or representative, Fire and Aviation Management Office (located in Washington, DC), and the National Interagency Coordination Center (NICC) located in Boise, ID. Support will be primarily for communications and aircraft and the establishment of base camps for deployed Federal health and medical teams in the disaster area.

2. Department of Defense

a. Alert GPMRC to provide DOD NDMS FCCs (Army, Air Force, and Navy) and VA NDMS FCCs reporting/regulating instruction to support disaster relief efforts;

b. Alert DOD NDMS FCCs to activate NDMS area operations/patient reception plans; initiate bed reporting based on GPMRC instructions;

c. In coordination with NDMSOSC, evacuate and manage patients as required from the disaster area to NDMS patient reception areas;

d. In coordination with DOT and other transportation support agencies, transport medical personnel, equipment, and supplies into the disaster area;

e. Provide logistical support to health/medical response operations;

f. Provide Active Duty medical units for casualty clearing/staging and other missions as needed, including aeromedical evacuation; mobilize and deploy Reserve and National Guard medical units, when authorized and necessary to provide support;

g. Coordinate patient reception and management in NDMS areas where military treatment facilities serve as local NDMS FCCs;

h. Provide military medical personnel to assist HHS in activities for the protection of public health (such as food, water, wastewater, solid waste disposal, vectors, hygiene, and other environmental conditions);

i. Provide available DOD medical supplies for distribution to mass care centers and medical care locations being operated for disaster victims;

j. Provide available emergency medical support to assist State and local governments within the disaster area. Such services may include triage, medical treatment, and the utilization of surviving DOD medical facilities within the disaster area;

k. Provide assistance in managing human remains, including victim identification and disposition;

l. Provide technical assistance, equipment, and supplies through the U.S. Army Corps of Engineers, as required, in support of HHS to accomplish temporary restoration of damaged public utilities affecting public health;

m. Immediately notify the Surgeons General of the Army, Air Force, and Navy if there is a likelihood that their support may be required; and

n. Provide technical facility and clerical expertise to assess the physical condition of the medical treatment facilities.

3. Department of Energy

a. Through the Radiation Emergency Assistance Center/Training Site (REAC/TS):

(1) Provide 24-hour direct and/or consulting assistance in assessing and treating the health and medical effects of radiological exposure and contamination involving general and high-risk populations;

(2) Offer intensive training to health professionals in medical management for radiological accidents;

(3) Provide counseling to victims of radiological accidents; and

(4) Provide technical advice and assistance regarding the handling and disposition of radiologically contaminated remains.

b. Through the Radiological Assistance Program (RAP):

(1) Provide regional resources (personnel, specialized equipment, and supplies) to evaluate, control, and mitigate radiological hazards to workers and the public;

(2) Assist in the decontamination of victims; and

(3) Assist State and local authorities in the monitoring and surveillance of the accident area.

c. Through the Atmospheric Release Advisory Capability (ARAC), provide real-time transport, dispersion, and dose predictions of atmospheric releases of radioactive and hazardous materials that can be used by authorities in taking protective actions related to sheltering and evacuation of people.

d. Through the Federal Radiological Monitoring and Assessment Center (FRMAC), to assist health and medical authorities in determining radiological dose information, provide coordinated gathering of radiological information and data; consolidated data sample analyses, evaluations, assessments, and interpretations; and technical information.

4. Department of Justice

a. Assist in victim identification, coordinated through the Federal Bureau of Investigation (FBI) Headquarters in Washington, DC;

b. Provide State and local governments with legal advice concerning the identification of the dead;

c. Provide HHS/OEP with relevant intelligence information of any credible threat or other situation that could potentially threaten public health. This support will be coordinated through FBI Headquarters in Washington, DC; and

d. Provide communication, transportation, and other logistical support to the extent possible. This support is provided through the FBI.

5. Department of Transportation

a. Assist in identifying and arranging for all types of transportation, such as air, rail, marine, and motor vehicle;

b. Assist in identifying and arranging for utilization of U.S. Coast Guard (USCG) aircraft in providing urgent airlift support when not otherwise required by ESF #1 — Transportation or the USCG;

c. Provide casualty distribution assistance from DOT resources subject to DOT statutory requirements; and

d. Coordinate with the Federal Aviation Administration for air traffic control support for priority missions.

6. Department of Veterans Affairs

a. Alert VA NDMS FCCs to activate NDMS area operations/patient reception plans, initiate bed reporting based on GPMRC instructions, and coordinate patient reception, management, and the provision of inpatient care through NDMS hospitals in areas where VA medical centers serve as local NDMS FCCs;

b. Assist in providing medical support to State and local governments within the disaster area. Such services may include triage, medical treatment, and the utilization of surviving VA medical centers within the disaster area;

c. Provide available medical supplies for distribution to mass care centers and medical care locations being operated for disaster victims; and

d. Provide assistance in managing human remains, including victim identification and disposition.

7. Agency for International Development, Office of Foreign Disaster Assistance

Provide assistance in coordinating international offers for health/medical support.

8. American Red Cross

a. Provide emergency first aid, supportive counseling, health care for minor illnesses and injuries to disaster victims in mass care shelters, DFOs, selected disaster cleanup areas, and other sites deemed necessary by the primary agency;

b. Assist community health personnel subject to the availability of staff;

c. Provide supportive counseling for the family members of the dead and injured;

d. Provide available personnel to assist in temporary infirmaries, immunization clinics, morgues, hospitals, and nursing homes;

e. Acquaint families with available health resources and services, and make appropriate referrals;

f. Provide blood and blood products through regional blood centers at the request of the appropriate agency; and

g. Provide coordination for uploading appropriate casualty/patient information from ESF #8 into the DWI system.

9. Environmental Protection Agency

Provide technical assistance and environmental information for the assessment of the health/medical aspects of situations involving hazardous materials.

10. Federal Emergency Management Agency

a. Assist NDMS in establishing priorities for application of health and medical support;

b. Assist in providing NDMS communications support;

c. Assist in providing information/liaison with emergency management officials in NDMS FCC areas; and

d. Provide logistics support as appropriate.

11. General Services Administration

Provide facilities, equipment, supplies, and other logistical support, including the acquisition of private sector ground and air transportation.

12. National Communications System

Provide communications support for medical command and control. This support will be coordinated through the Office of the Manager.

13. U.S. Postal Service

Assist in the distribution and transportation of medicine and pharmaceuticals to the general public affected by a major disaster or emergency as needed.

VI. References

A. DOD Directive 6010.17, National Disaster Medical System, December 28, 1988.

B. DOD Directive 3025.1, Military Support to Civil Authorities, January 15, 1993.

C. 55 FR 2885, Office of the Assistant Secretary for Health; Statement of Organization, Functions, and Delegations of Authority, January 29, 1990.

D. 55 FR 2879, Office of the Secretary; Statement of Organizations, Functions, and Delegations of Authority, January 29, 1990.

E. Public Health Service Disaster Response Guides, May 1987.

F. Facts on the National Disaster Medical System, February 1995.

G. National Disaster Medical System — Concept of Operations, January 1991.

H. National Disaster Medical System — Operations Support Center Manual, April 1991.

I. National Disaster Medical System — Federal Coordinating Center Guide, January 1992.

J. National Disaster Medical System — Disaster Medical Assistance Team Organization Guide, May 1992.

K. The Public Health Consequences of Disasters, Centers for Disease Control, U.S. Public Health Service, September 1989.

L. 61 FR 21470, Office of the Secretary; Statement of Organization, Functions, and Delegations of Authority, May 10, 1996.

M. 60 FR 56605, Office of the Secretary and Public Health Services; Statement of Organization, Functions, and Delegations of Authority, November 9, 1995.

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